ARTICLE VII – CONVERSION AND CONTINUATION OF COVERAGE

A. CONVERSION

1. Employees

   a. An employee who was covered under this Plan of Benefits for at least six (6) months and whose employment with the Employer is terminated while this Plan of Benefits is in effect will be entitled to a conversion policy (upon request), like that generally issued on behalf of the Corporation, without evidence of insurability and after exhaustion of any continuation coverage otherwise available to the employee.

   b. Such employee must submit an application for insurance coverage and pay the appropriate premium for such coverage. The application for conversion insurance coverage must be submitted within sixty (60) days following the termination of coverage under this Plan of Benefits.

   c. If the application for conversion insurance coverage is submitted timely and the appropriate premium is paid within thirty-one (31) days, conversion coverage will be effective under the conversion policy as of the date of termination of employment.

   d. If the application for conversion insurance coverage is submitted timely but the premium is paid after the thirty-first (31st) day but before the sixty (60) day election period expires, conversion coverage will be effective on the date the application for conversion insurance coverage is submitted, provided, that in such instance, there will be no conversion coverage for expenses incurred before the date the application for conversion insurance coverage was submitted.

   e. Any Probationary Periods set forth in the conversion policy that had previously been met under this Plan of Benefits shall be considered as being met to the extent that such Probationary Periods were met under this Plan of Benefits.

2. Dependents

   a. If a Dependent's coverage under this Plan of Benefits terminates or in the event of the death of the Employee, such Dependent will be entitled to a conversion policy, upon request, like that generally issued on behalf of the Corporation, without evidence of insurability and after exhaustion of any continuation group insurance coverage for which such Dependent may be eligible by applying for such a policy form the Corporation or such other insurance carrier as the Corporation may designate.

   b. Such application for conversion insurance coverage must be submitted within sixty (60) days after coverage under this Plan of Benefits terminates. If the application for conversion insurance coverage is submitted timely and the appropriate Premium is paid within thirty-one (31) days, conversion coverage will be effective under the conversion policy as of the date of termination of the Employee's employment or death.

   c. If the application for conversion insurance coverage is submitted timely but the premium is paid after the thirty-first (31st) day but before the sixty (60) day election period expires, coverage will be effective on the date the Membership Application is submitted, provided, that in such instance, there will be no conversion coverage for medical expenses incurred before the date the Membership Application was submitted.

d. Any Probationary Periods set forth in the conversion policy that had previously been met under this Plan of Benefits shall be considered as being met to the extent that such Probationary Periods were met under this Plan of Benefits.

3. Divorced Spouse

Upon the entry of a valid order or decree of divorce between an Employee and such Employee's Dependent spouse, the divorced spouse shall be entitled (upon request) to a conversion policy, without evidence of insurability, upon submission of an application of insurance made to the Corporation within sixty (60) days following the divorce decree and upon payment of the appropriate premium. Any Probationary Periods set forth in the conversion policy that had previously been met under this Plan of Benefits shall be considered as being met to the extent that such Probationary Periods were met under this Plan of Benefits.

4. No Conversion Rights if Other Coverage Exists

Except as stated in Section VII. A. 3. above, the Corporation has no obligation to issue a conversion policy to a Member if that Member is covered by or is eligible for coverage under a similar health insurance policy or plan.

B. CONTINUATION

1. State Law

In addition to any extension of Benefits or conversion rights a Member may have, each Member has the right, upon request, to continue such Member's coverage under this Plan of Benefits for that portion of the month remaining at termination plus six (6) additional months. The Member must make payment of the appropriate premium (including any Employer portion) to the Employer in advance for such coverage. To be eligible for such coverage, the Member must have been continuously covered under the Employer's Group Health Plan for at least six (6) months and have been terminated for a reason other than non-payment of premium. If a Member is entitled to coverage under COBRA for a greater period of time, to Medicare benefits, or for other group health coverage, such Member is not entitled to continuation coverage under this section. This Plan of Benefits or a successor Plan must remain in force and the Member must pay the applicable premium in advance for the Member to receive this continuation coverage.

2. COBRA

a. Plan Administrator and Sponsor.

The Employer is both the Plan Administrator and Employer of this Plan of Benefits. The Employer agrees to offer continuation of coverage pursuant to the provisions of COBRA, if required, to eligible Members while this Plan of Benefits is in force. COBRA requires the Employer to allow eligible individuals to continue their health coverage for eighteen (18), twenty-nine (29), or thirty-six (36) months, depending on the Qualifying Event.

b. Disabled Members.

To be eligible for up to twenty-nine (29) months of continuation of coverage due to disability, an Employee or Dependent who is determined to be disabled under Title II or XVI of the Social Security Act with a disability onset date either before the COBRA event or within the first sixty (60) days of the COBRA continuation coverage must provide a copy of the notice of the determination of disability to the Employer within sixty (60) days of the determination of disability and before the end of the first eighteen (18) months of COBRA coverage and must also notify the Employer within thirty (30) days of any determination that the Employee or Dependent is no longer disabled.

c. Notice of Qualifying Event by the Member.

Each Member is responsible for notifying the Employer within sixty (60) days of such Member's Qualifying Event due to divorce, separation, or when a Dependent ceases dependency. If the Member does not give such notice, the Member is not entitled to continuation coverage.

d. Notice by the Employer to the Member

The Employer must notify the Corporation no later than thirty (30) days after the date the Member loses coverage due to a COBRA event. The Corporation must send a COBRA Election Notice to each Member no later than fourteen (14) days after receipt of the notice from the Employer. Notice to the Dependent spouse is deemed notice to any Dependent of the spouse.

e. Election of Coverage.

Continuation coverage is not automatic. The Member must elect continuation coverage within sixty (60) days of the later of:

i. The date the Member's coverage under this Plan of Benefits ceases because of the Qualifying Event;

ii. The date the Member is sent notice of the right to elect continuation coverage by the Employer; or

iii. The date the Member becomes an "eligible individual" (as that term is used in the Trade Act of 2002) provided that such election is made not later than six (6) months after the Qualifying Event that gives rise to eligibility under the Trade Act of 2002.

f. Premium Required.

The Member will be required to pay a premium for the continuation coverage and shall have the option to make payment in monthly installments. The Member has forty-five (45) days from the date of election to pay the first premium, which includes the period when coverage commenced, regardless of the date that the first premium is due. Subsequent premiums are subject to a Grace Period.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance ("eligible individuals" as more fully defined in the Trade Act of 2002). Under the new tax provision, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance (as defined in the Trade Act of 2002), including continuation coverage. If a Member has questions about these new tax provisions, the Member may call the Health Care Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act of 2002 is also available at www.doleta.gov/tradeact/2002act_index.asp.

g. Length of COBRA Coverage.

The maximum period for continuation coverage for a Qualifying Event involving termination of employment or a reduction in hours is eighteen (18) months. An Employee or Dependent who is determined to be disabled under Title II or XVI of the Social Security Act before the COBRA event or within the first sixty (60) days of COBRA continuation coverage is entitled to twenty-nine (29) months of continuation coverage, but only if such Employee or Dependent has provided notice of the determination of disability within sixty (60) days after determination is issued and before the end of eighteen (18) months of coverage. If a second Qualifying Event occurs within this period of continuation coverage, the coverage for any affected Dependent who was a Member under this Plan of Benefits both at the time of the first and the second Qualifying Events may be extended up to thirty-six (36) months from the first Qualifying Event. For all other Qualifying Events, the maximum period of coverage is thirty-six (36) months. Below is a list of circumstances and the period of COBRA coverage for each circumstance.

i. Eighteen (18) months for Employees whose working hours are reduced--from full-time to part-time, for instance, and any Dependents who also lose coverage for this reason.

ii. Eighteen (18) months for Employees who voluntarily quit work, and any Dependents who also lose coverage for this reason.

iii. Eighteen (18) months for Employees who are part of an economic layoff, and any Dependents who also lose coverage for this reason.

iv. Eighteen (18) months for Employees who are fired, unless the firing is due to gross misconduct, and any Dependents who also lose coverage for this reason.

v. Twenty-nine (29) months for Employees and all covered Dependents who are determined to be disabled under the Social Security Act during the first sixty days after termination of employment or reduction of hours of employment. Notice of the Social Security Disability determination must be given to the Purchaser within 60 days of the determination of disability and before the end of the first 18 months of continuation of coverage.

vi. Thirty-six (36) months for Employees' widows or widowers and their Dependent Children.

vii. Thirty-six (36) months for separated or divorced husbands or wives and their Dependent Children.

viii. Thirty-six (36) months for Dependent Children who lose coverage because they no longer meet the Plan's definition of a Dependent Child.

ix. Thirty-six (36) months for Dependents who are not eligible for Medicare when the Employee is eligible for Medicare and no longer has coverage with the Employer.

x. For Plans providing coverage for retired Employees and their dependents, a special rule applies for such persons who would lose coverage due to the Purchaser filing for Title 11 Bankruptcy. (Loss of coverage includes a substantial reduction of coverage within a year before or after the bankruptcy filing.) Upon occurrence of such an event, retired Employees and their eligible Dependents may continue their coverage under the Plan until the date of death of the retiree. If a retiree dies while on this special continued coverage, surviving Dependents may elect to continue coverage for up to thirty-six (36) additional months.

3. USERRA

a. In any case in which an Employee or any of such Employee's Dependents has coverage under this Plan of Benefits, and such Employee is not Actively at Work by reason of active duty service in the uniformed services, the Employee may elect to continue coverage under this Plan of Benefits as provided in this ArticleVII(B)(3). The maximum period of coverage of the Employee and such Employee's Dependents under such an election shall be the lesser of:

i. The twenty-four (24) month period beginning on the date on which the Employee's absence from being Actively at Work by reason of active duty service in the uniformed services begins; or

ii. The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under USERRA.

The continuation of coverage period under USERRA will be counted toward any continuation of coverage period available under COBRA.

b. An Employee who elects to continue coverage under this section of this Plan of Benefits must pay one hundred and two percent (102%) such Employee's normal Premium. Except that, in the case of an Employee who performs service in the uniformed services for less than thirty-one (31) days, such employee will pay the normal contribution for the thirty-one (31) days.

c. An employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under this Plan of Benefits upon re-employment. Except as provided in Article VII(B)(3)(d), upon re-employment and reinstatement of coverage no new exclusion or Probationary Period will be imposed in connection with the reinstatement of such coverage if an exclusion or waiting period would normally have been imposed. This Article VII(B)(3)(c) applies to the Employee who is re-employed and to a Dependent who is eligible for coverage under this Plan of Benefits by reason of the reinstatement of the coverage of such employee.

d. Article VII(B)(3)(c) shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

C. QUALIFIED MEDICAL CHILD SUPPORT ORDER

If this Plan of Benefits is an integral part of a Plan governed by ERISA, then this Plan of Benefits shall pay Covered Expenses in accordance with the applicable requirements of any Qualified Medical Child Support Order.

1. Procedural Requirements.

   a. Timely Notifications and Determinations.

      In the case of any Medical Child Support Order received by the Corporation:

      i. The Employer as the Plan Administrator shall promptly notify the Employee and each Alternate Recipient of the receipt of the Medical Child Support Order and the Corporation's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders; and,

      ii. Within a reasonable period after receipt of such Qualified Medical Child Support Order, the Employer shall determine whether such order is a Qualified Medical Child Support Order and notify the Employee and each Alternate Recipient of such determination.

   b. Establishment of Procedures for Determining Qualified Status of Orders.

      The Employer as the Plan Administrator shall establish reasonable procedures to determine whether Medical Child Support Orders are Qualified Medical Child Support Orders and to administer the provision of Covered Expenses under of such qualified orders. The Employer's procedures:

      i. Shall be in writing;

      ii. Shall provide for the notification of each person specified in a Medical Child Support Order as eligible to receive Benefits under this Plan of Benefits (at the address included in the Medical Child Support Order) of the Employer's procedures promptly upon receipt by the Plan Administrator of the Medical Child Support Order; and,

      iii. Shall permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

   c. Actions Taken by Fiduciaries.

      If a Plan fiduciary for this Plan of Benefits acts in accordance with these procedural requirements in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then this Plan of Benefits obligation to the Member and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

2. Treatment of Alternate Recipients.

   a. Under ERISA.

      A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a beneficiary under this Plan of Benefits for purposes of any provisions of ERISA, as amended, and shall be treated as a participant under the reporting and disclosure requirements of ERISA.

b. Direct Provision of Benefits Provided to Alternate Recipients.

Any payment for Covered Expenses made by the Corporation pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

c. Plan Enrollment and Payroll Deductions.

If an Employee remains covered under this Plan of Benefits but fails to enroll an Alternate Recipient under this Plan of Benefits after receiving notice of the Qualified Medical Child Support Order from the Employer, the Employer shall enroll the Alternate Recipient and deduct the additional premium from the Employee's paycheck.

d. Termination of Coverage.

Except for any coverage continuation rights otherwise available under this Plan of Benefits, the coverage for the Alternate Recipient shall end on the earliest of:

i. The date the Employee's coverage ends;

ii. The date the Qualified Medical Child Support Order is no longer in effect;

iii. The date the Employee obtains other comparable health coverage through another insurer or Plan to cover the Alternate Recipient; or

iv. The date the Employer eliminates family health coverage for all of its Employees.

ARTICLE VIII – SUBROGATION AND REIMBURSEMENT

In the event benefits are provided to or on behalf of a Member under the terms of this Plan of Benefits, the Member agrees, as a condition of receiving benefits, to transfer to the Corporation all rights to recover damages in full for such benefits when the injury occurs through the act or omission of another person, firm, corporation, organization or business entity. The Corporation shall be subrogated, at its expense, to the rights of recovery of such Member against any third party who is liable, responsible, or otherwise makes a payment for the injury.

If, however, the Member has an injury that occurred by an act or omission of a liable third party, and the Member receives a settlement, judgment, or other payment relating to the injury from another person, firm, corporation, organization or business entity, the Member agrees to reimburse the Corporation for benefits paid by the Corporation relating to the injury.

For purposes of this Article, a liable third party and/or liable insurance coverage include parties and coverages that are responsible or otherwise make a payment for the Member's injury even though liability or other culpability may be denied.

The Corporation's subrogation/reimbursement rights apply to any judgment and/or settlement proceeds received by the insured from or on behalf of the liable third party.

The Corporation's subrogation / reimbursement interest extends to all benefits relating to the injury even if claims for those benefits were not submitted to the Corporation for payment at the time the Member received the settlement, judgment or payment.

The Corporation's right of recovery may be from the liable third party, any liability or other insurance covering the liable third party, malpractice insurance, the Member's own uninsured motorist insurance and/or underinsured motorist insurance.

If the Director of Insurance, or his designee, upon being petitioned by the Member, determines that the exercise of subrogation and/or reimbursement by the Corporation is inequitable and commits an injustice to the Member, subrogation and/or reimbursement will not be allowed. This determination by the director or his designee may be appealed to the Administrative Law Judge Division as provided by law.

The Corporation will pay reasonable attorney's fees and costs from the amount recovered.

The Member shall not do anything to hinder the Corporation's right of subrogation and/or reimbursement. The Member shall cooperate with the Corporation, execute all documents, and do all things necessary to protect and secure the Corporation's right of subrogation and/or reimbursement.

ARTICLE IX - WORKERS' COMPENSATION PROVISION

This policy does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member elects exemption from available Workers' Compensation coverage; waives entitlement to Workers' Compensation benefits for which he/she is eligible; failed to timely file a claim for Workers' Compensation benefits; or, the Member sought treatment for the injury or illness from a provider which is not authorized by the Member's employer.

If the Corporation pays benefits for an injury or illness and the Corporation determines the Member also received Workers' Compensation benefits by means of a settlement, judgment, or other payment for the same injury or illness, Member shall reimburse the Corporation in full all benefits paid by the Corporation relating to the injury or illness.

The Corporation's right of recovery will be applied even if: the Workers' Compensation benefits are in dispute or are made by means of a compromised, doubtful and disputed, clincher or other settlement; no final determination is made that the injury or illness was sustained in the course of or resulted from the Member's employment; the amount of Workers' Compensation benefits due to medical or health care is not agreed upon or defined by the Member or the Workers' Compensation carrier; or, the medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

As a condition of receiving benefits under this Plan of Benefits, the Member agrees to notify the Corporation of any Workers' Compensation claim he/she may make and agrees to reimburse the Corporation as described herein. The Member shall not do anything to hinder the Corporation's right of recovery. The Member shall cooperate with the Corporation, execute all documents, and do all things necessary to protect and secure the Corporation's right of recovery, including assert a claim or lawsuit against the Workers' Compensation carrier or any other insurance coverages to which the Member may be entitled. Failure to cooperate with the Corporation will entitle the Corporation to withhold benefits due the Member under this Plan of Benefits. Failure to reimburse the Corporation as required under this Article will entitle the Corporation to invoke the Workers' Compensation Exclusion and deny payment for all claims relating to the injury or illness and/or deny future benefit payments for any such Member until the reimbursement amount has been paid in full.

ARTICLE X – ERISA RIGHTS

If this Plan of Benefits is covered by ERISA, each Member in this Plan of Benefits is entitled to certain rights and protections under ERISA. ERISA provides that all Members shall be entitled to:

A. RECEIVE INFORMATION ABOUT THE PLAN OF BENEFITS

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing this Plan of Benefits, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by this Plan of Benefits with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of this Plan of Benefits, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may assess a reasonable charge for the copies.

3. Receive, upon request, a summary of this Plan of Benefits' annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.

B. CONTINUATION COVERAGE

1. Members are entitled to continue health care coverage for themselves and their Dependents if there is a loss of coverage under this Plan of Benefits as a result of a Qualifying Event. The Member or Dependents may have to pay for such continuation coverage. Employee Members should review the documents governing COBRA continuation coverage rights.

2. Members may be entitled to a reduction or elimination of Pre-Existing Condition Waiting Periods if the Member has Creditable Coverage from another Group Health Plan. Members should be provided a certificate of Creditable Coverage, free of charge, from the Member's prior Group Health Plan or health insurance issuer when:

   a. The Member loses coverage under such Group Health Plan; or,

   b. When the Member becomes entitled to elect COBRA continuation coverage; or,

   c. When the Member's COBRA continuation coverage ceases.

3. A Member is entitled to a certificate of Creditable Coverage if such Member requests it before losing coverage, or if the Member requests it up to twenty-four (24) months after losing coverage. Without evidence of Creditable Coverage, the Member may be subject to a Pre-Existing Condition Waiting Period for twelve (12) months (eighteen (18) months for Late Enrollees) after the Member's enrollment date.

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Members, ERISA imposes duties upon the people who are responsible for the operation of an employee welfare benefit plan. The people who administer an employee welfare benefit plan are called "fiduciaries," and have a duty to do so prudently and in the interest of the Members. The Employer is a fiduciary of this Plan of Benefits.

D. ENFORCEMENT OF EMPLOYEE RIGHTS

1. If a Member's claim for a Benefit is denied or ignored, in whole or in part, such Member has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

2. Under ERISA, there are steps a Member can take to enforce the rights described above. For instance, if a Member requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, such Member may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay such Member up to $110 a day until such Member receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Member has a claim for Benefits that is denied or ignored, in whole or in part, such Member may file suit in a state or federal court. In addition, if a Member disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, such Member may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Member is discriminated against for asserting such Member's rights, such Member may seek assistance from the U.S. Department of Labor, or such Member may file suit in a federal court. The court will decide who should pay court costs and legal fees. If a Member is successful the court may order the person the Member has sued to pay these costs and fees. If the Member loses, the court may order such Member to pay these costs and fees, for example, if it finds such Member's claim is frivolous.

3. No one, including the Employer, the Members' union, or any other person, may fire an Employee or otherwise discriminate against an Employee in any way to prevent an Employee from obtaining a Benefit or exercising the Employee's rights under ERISA.

E. ASSISTANCE WITH QUESTIONS

If a Member has any questions about this Plan of Benefits, the Member should contact the Plan Administrator. If a Member has any questions about this statement or about a Member's rights under ERISA, or if a Member needs assistance in obtaining documents from the Plan Administrator, the Member should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. A Member may also obtain certain publications about the Member's rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE XI - CLAIMS FILING AND APPEAL PROCEDURES

A. CLAIMS FILING PROCEDURES

1. When a Participating Provider renders services, generally, the Participating Provider should either file the claim on the Member's behalf or provide an electronic means for the Member to file a claim while the Member is in the Participating Provider's office. However, the Member is responsible for ensuring that the claim is filed.

2. Written notice of receipt of services on which a claim is based must be furnished to the Corporation, at its address on the Identification Card, within twenty (20) days of the beginning of services, or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Member can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, the Corporation will furnish or cause a claim form to be furnished to the Member. If the claim form is not furnished within fifteen (15) days after the Corporation receives the notice, the Member will be deemed to have complied with the requirements of this Plan of Benefits as to proof of loss. The Member must submit written proof covering the character and extent of the services within the policy time fixed for filing proof of loss.

3. For Benefits not provided by a Participating Provider, the Member is responsible for filing claims with the Corporation. When filing the claims, the Member will need the following:

   a. A claim form for each Member. Members can get claim forms from a member services representative at the telephone number indicated on the Identification Card or via the Corporation's website, www.SouthCarolinaBlues.com.

   b. Itemized bills from the Provider(s). These bills should contain all the following:

      i. Provider's name and address;

      ii. Member's name and date of birth;

      iii. Member's Identification Card number;

      iv. Description and cost of each service;

      v. Date that each service took place; and

      vi. Description of the illness or injury and diagnosis.

   c. Members must complete each claim form and attach the itemized bill(s) to it. If a Member has other insurance that already paid on the claim(s), the Member should also attach a copy of the other Plan's explanation of benefits notice.

   d. Members should make copies of all claim forms and itemized bills for the Member's records since they will not be returned. Claims should be mailed to the Corporation's address listed on the claim form.